Using Registry Data to Inform Client Outreach Efforts



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Project Overview



- HIP (Health Integration Project)
- Family Services Inc. Gaithersburg, MD
- Strategic Partners: Threshold Services Inc. and CCI
- Approximately 600 clients served to date
- Approximately 50% have community-based PCPs
- Reassessment rate at end of FY 2012: 88%

Evaluation Overview



Our evaluation includes all SAMHSA-required data and additional data such as:

- alcohol use
- drug use
- self-reported health information using the SF-36

Mechanical health data is also collected during interim three-month appointments.

Evaluation Overview



Use of data to support CQI – Continuous Quality Improvement.

Use of data to:

- Target interventions to specific sub-groups of clients
- Monitor client/program progress
- Provide meaningful feedback to providers, clients and partners.

Evaluation Overview – Missing Data



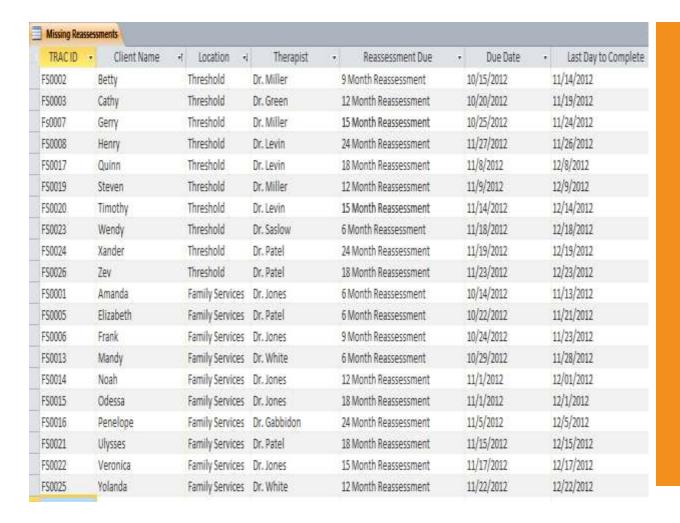
- Requires an ongoing monitoring of data to ensure that information is being collected and clients are receiving needed clinical care.
- Can be accomplished in many ways, we are using an Access database and related queries/reports.

Access Database - Overview



	Baseline Health										
4	TRAC ID -	Name •	PCP +	DOB +	BL Visit Date 🕶	BL Height 🕶	BL Weight 🔻	BL Waist 🕶	BL BP Systolic 🔻	BL BP Diastolic 🔻	BL Lab Date 🔻
+	FS0001	Amanda	Dr. Jones	1/1/1950	2/1/2011	62	155	84	120	80	2/5/201:
+	FS0002	Betty	Dr. Kitson	2/2/1951	2/1/2011	61	145	82	125	90	2/7/201:
<u>+</u>	FS0003	Cathy	Dr. Currin	3/3/1952	2/2/2011	60	180	90	127	100	2/7/201
+	FS0004	Debra	Dr. Pina	4/4/1953	2/4/2011	54	175	90	130	90	
+	FS0005	Elizabeth	Dr. Winger	5/5/1954	2/5/2011	53	155	85	128	110	3/1/201
+	FS0006	Frank	Dr. Miller	6/6/1955	2/7/2011	72	245	120	160	120	2/15/201
Į.	Fs0007	Gerry	Dr. Hernandez	7/7/1956	2/15/2011	64	260	125	140	110	2/15/201
I+	FS0008	Henry	Dr. Currin	8/8/1957	2/17/2011	70	255	130	135	100	
Đ.	FS0009	Isabel	Dr. Duffy	9/9/1958	2/19/2011	66	180	100	135	90	2/20/201
·	FS0010	Jane	Dr Levinson	10/10/1959	2/22/2011	67	174	94	142	100	3/1/201
Į÷	FS0011	Kate	Dr. Hyde	11/11/1960	2/23/2011	70	166	93	137	91	3/2/201:
Į÷	FS0012	Linda	Dr. Jones	12/12/1961	3/1/2011	64	156	85	120	90	3/20/2013
Đ.	FS0013	Mandy	Dr. Winger	1/1/1962	3/2/2011	63	167	87	120	90	
+	FS0014	Noah	Dr. Duncan	2/2/1963	3/4/2011	69	199	92	125	100	3/7/201
Į÷	FS0015	Odessa	Dr. Leo	3/3/1964	3/7/2011	59	310	130	127	90	3/7/201:
Į÷	FS0016	Penelope	Dr. Kitson	4/4/1965	3/9/2011	56	298	105	130	110	3/15/201
<u>+</u>	FS0017	Quinn	Dr. Bergman	5/5/1966	3/12/2011	58	168	91	120	80	3/15/201
+	FS0018	Rachel	Dr. Hernandez	6/6/1967	3/15/2011	64	254	107	135	90	3/15/201
Į÷	FS0019	Steven	Dr. Levinson	7/7/1968	3/17/2011	70	274	110	110	90	3/19/201:
Į÷	FS0020	Timothy	Dr. Jones	8/8/1969	3/19/2011	75	244	115	127	100	3/22/2013
Į÷	FS0021	Ulysses	Dr. Duncan	9/9/1970	3/19/2011	56	265	117	140	110	
·	FS0022	Veronica	Dr. Hyde	10/10/1971	3/21/2011	58	210	95	137	109	3/25/2013
Į÷	FS0023	Wendy	Dr. Pina	11/11/1972	3/22/2011	59	285	109	130	90	3/22/201
Į.	FS0024	Xander	Dr. Miller	12/12/1973	3/24/2011	74	285	120	150	120	3/27/201:
<u>+</u>	FS0025	Yolanda	Dr. Jones	1/1/1974	4/2/2011	58	235	117	140	110	4/5/201
+	FS0026	Zev	Dr. Currin	2/2/1975	4/5/2011	72	300	126	135	95	5/1/201

Reporting – Missing Reassessments





Reporting – CCI Staff

Similar to TRACgenerated report

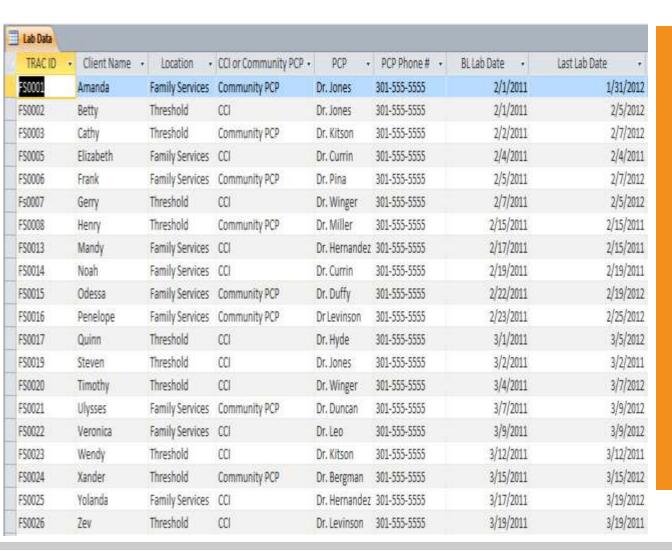
Only lists clients with missing visit information

Our version contains client names, clinic information, and BH provider information

Also includes information on interim appointments (3-month, 9-month etc.)

Reporting - Missing Lab Data





Reporting – Project Staff

Query that pulls the last lab date for every client

Tailor report to only pull clients with:

 Out-of-date lab information

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- By Site
- By PCP

* Fictional client data



Name +1	Family_Services_or_Threshold →	CCI or Community PCP 🚽	Blood Pressure -
Amanda	Family Services	CCI	140/105
Betty	Threshold Services	CCI	160/130
Cathy	Family Services	CCI	120/90
David	Threshold Services	Community PCP	135/97
Illa	Family Services	CCI	140/115
Frank	Family Services	CCI	120/85
Gina	Threshold Services	CCI	110/80
Helen	Family Services	Community PCP	135/100
nga	Threshold Services	Community PCP	145/119
acob	Family Services	CCI	100/75
Celly	Family Services	CCI	160/125
Vlatt	Threshold Services	CCI	180/130
Nate	Family Services	Community PCP	120/90
Oscar	Threshold Services	Community PCP	110/80
Penny	Family Services	CCI	150/120
Quinn	Family Services	CCI	140/110
Rebecca	Threshold Services	CCI	155/121
Steve	Family Services	Community PCP	130/90
Гаті	Threshold Services	Community PCP	120/85
Jlysses	Family Services	CCI	120/85
/eronica	Family Services	CCI	120/90
Nendy	Threshold Services	CCI	150/120
Kavier	Family Services	Community PCP	135/95
/olanda	Threshold Services	Community PCP	140/112
Zev	Family Services	CCI	130/90

Targeting Interventions to High Risk Populations

Use the Access database to identify specific high-risk people for interventions targeting those conditions.



Name •	Family_Services_or_Threshold -	CCI or Community PCP -	Total Cholesterol → Lo
Penny	Family Services	CCI	387
Quinn	Family Services	CCI	325
Kelly	Family Services	CCI	300
Veronica	Family Services	CCI	274
Cathy	Family Services	CCI	254
Jacob	Family Services	CCI	250
Inga	Threshold Services	Community PCP	240
David	Threshold Services	Community PCP	221
Betty	Threshold Services	CCI	213
Matt	Threshold Services	CCI	210
Steve	Family Services	Community PCP	210
Oscar	Threshold Services	Community PCP	207
Tami	Threshold Services	Community PCP	200
Amanda	Family Services	CCI	200
Helen	Family Services	Community PCP	199
Yolanda	Threshold Services	Community PCP	197
Ella	Family Services	CCI	197
Ulysses	Family Services	CCI	196
Nate	Family Services	Community PCP	195
Zev	Family Services	CCI	184
Xavier	Family Services	Community PCP	178
Rebecca	Threshold Services	CCI	175
Frank	Family Services	CCI	165
Gina	Threshold Services	CCI	155
Wendy	Threshold Services	CCI	146

Targeting Interventions to High Risk Populations

Use the database to sort individuals based on risk factors.

Outreach to/target individuals in the highest risk factor categories first.



Name	 Family_Services_or_Threshold 	 CCI or Community PCP 	Smoker?
Zev	Family Services	CCI	▽
Nate	Family Services	Community PCP	✓
Oscar	Threshold Services	Community PCP	V
Quinn	Family Services	CCI	V
Rebecca	Threshold Services	CCI	V
Tami	Threshold Services	Community PCP	V
Ulysses	Family Services	CCI	▽
Veronica	Family Services	CCI	V
Xavier	Family Services	Community PCP	▽
Kelly	Family Services	CCI	V
Amanda	Family Services	CCI	V
Betty	Threshold Services	CCI	V
Cathy	Family Services	CCI	V
David	Threshold Services	Community PCP	V
Frank	Family Services	CCI	▽
Helen	Family Services	Community PCP	V
Jacob	Family Services	CCI	V
Ella	Family Services	CCI	
Matt	Threshold Services	CCI	
Wendy	Threshold Services	CCI	
Steve	Family Services	Community PCP	
Gina	Threshold Services	CCI	
Penny	Family Services	CCI	
Inga	Threshold Services	Community PCP	
Yolanda	Threshold Services	Community PCP	

Targeting Interventions to High Risk Populations

Or quickly identify smokers for a tobacco cessation activity.



Name -	Family Services or Threshold 🔻	CCI or Community PCP -	Blood Pressure
Matt	Threshold Services	CCI	180/130
Betty	Threshold Services	CCI	160/130
Kelly	Family Services	CCI	160/125
Rebecca	Threshold Services	CCI	155/121
Wendy	Threshold Services	CCI	150/120
Penny	Family Services	CCI	150/120
Inga	Threshold Services	Community PCP	145/119
Ella	Family Services	CCI	140/115
Yolanda	Threshold Services	Community PCP	140/112
Quinn	Family Services	CCI	140/110
Amanda	Family Services	CCI	140/105
Helen	Family Services	Community PCP	135/100
David	Threshold Services	Community PCP	135/97
Xavier	Family Services	Community PCP	135/95
Zev	Family Services	CCI	130/90
Steve	Family Services	Community PCP	130/90
Frank	Family Services	CCI	120/85
Cathy	Family Services	CCI	120/90
Veronica	Family Services	CCI	120/90
Ulysses	Family Services	CCI	120/85
Nate	Family Services	Community PCP	120/90
Tami	Threshold Services	Community PCP	120/85
Gina	Threshold Services	CCI	110/80
Oscar	Threshold Services	Community PCP	110/80
Jacob	Family Services	CCI	100/75

Targeting
Interventions to
High Risk
Populations

Or, individuals with elevated BP for a hypertension program.

HIP Client Health Report





Client Name:	Jane Doe	TRACID: 12345	
Indicator (Goal)	12/12/2011	2/6/2012	8/8/2012
BMI (18.5 -24.9)	48*	45*	42*
Weight	300	280	260
BP Systolic (<=120)	140*	110	125*
BP Diastolic (<=90)	120*	110*	90
LDL (<100)	160*	140*	110*
HDL (>60)	40*	50*	65
Triglycerides (<150)	300*	200*	145
Fasting Glucose (<100)	200*	170*	95
HbA1c (<5.7)	10*	5	9*
Lab Date	12/23/2011	2/9/2012	9/1/2012
Smoking	Yes*	Yes*	Yes*
AUDIT-Alcohol (<8)	0	9*	7
DAST-Drug Use (<3)	4*	2	0
PHQ9 -Depression (<10)	12*	6	6

 Sample HIP Health Report provided to therapists, psychiatrists and other BH staff.

Client Health Goals and Readiness: This is where the provider can write notes and goals for the client.

Action Steps:

Action Step 1

Action Step 2

Action Step 3

 BH staff asked to incorporate information from health report into treatment planning.

 Importance of training for BH staff

Readiness Ruler

Not at all 0cm 1 2 3 4 5 6 7 8 9 10 Very

* Fictional client data 13

Conclusion



Questions?

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